TRAUMA- AND STRESSOR-RELATED DISORDERS

Reactive Attachment Disorder

RAD

DSM-5-TR 313.89 | ICD-10-CM F94.1

Emotionally withdrawn, inhibited behavior toward caregivers in a young child who experienced grossly insufficient care before age 5.

PREVALENCE	AGE WINDOW	SEX RATIO	COURSE
Rare (<1%); higher in care	9 months to 5 years	No consistent difference	Remits with stable caregiving

CLINICAL PICTURE

- The child rarely seeks comfort when distressed and rarely responds to comfort when it is offered, even by a familiar and willing caregiver.
- Positive affect is minimal, and unexplained irritability, sadness, or fearfulness surfaces during nonthreatening interactions with caregivers.
- Social and emotional reciprocity is limited: little eye contact, sparse social smiling, and blunted response to caregiver bids for interaction.
- History reveals neglect, repeated changes of primary caregiver, or institutional rearing with high child-to-caregiver ratios and rotating staff.
- Foster and adoptive parents describe a child who seems indifferent to their presence and does not use them as a secure base for exploration.
- Developmental delays, growth failure, and stereotypies frequently accompany the picture in previously institutionalized young children.

DIAGNOSTIC CRITERIA AT A GLANCE

- A consistent pattern of inhibited, emotionally withdrawn behavior toward adult caregivers, shown by minimal comfort-seeking and minimal response to comfort.
- At least two of three social and emotional disturbances: limited social and emotional responsiveness, restricted positive affect, and unexplained irritability, sadness, or fearfulness.
- The child must have experienced a pattern of extremes of insufficient care, such as social neglect, repeated caregiver changes, or institutional rearing.
- The disturbance must be evident before age 5, the child must have a developmental age of at least 9 months, and autism spectrum disorder must be excluded.
- Specify persistent when the condition has been present for more than 12 months and severe when all symptoms are present at relatively high levels.

NEUROBIOLOGY & PHYSIOLOGY

- Early psychosocial deprivation blunts the HPA axis, producing flattened diurnal cortisol slopes that persist for years after placement.
- Institutionalized children show reduced cortical gray and white matter volume and lower EEG alpha power, consistent with cortical hypoactivation.
- Amygdala volume and reactivity are altered after deprivation, disrupting the caregiver-buffered regulation of threat response seen in reared children.
- Deprivation impairs myelination and white matter integrity, and recovery depends strongly on the age at which stable caregiving actually begins.
- Sensitive periods matter: placement into high-quality foster care before roughly 24 months predicts markedly better attachment and cognitive outcomes.
- Chronic early stress is associated with shorter telomeres, altered immune signaling, and elevated medical morbidity later in development.

PSYCHOLOGICAL MECHANISMS

- Attachment theory requires a discriminated attachment figure, and extremes of insufficient care prevent such a figure from forming at all.
- Without contingent caregiver responses the child never learns that distress signals reliably produce relief, so the signaling itself extinguishes.
- The missing internal working model leaves the child with no strategy for using adults to regulate arousal in frightening or novel situations.
- Symptoms respond to caregiving quality rather than to child-directed play therapy, which is why intervention targets the caregiver first.
- Once a selective attachment forms with a sensitive caregiver, symptoms typically remit, unlike disinhibited social engagement disorder.

DIFFERENTIAL & COMORBIDITY

- Autism spectrum disorder shows restricted interests and repetitive behavior without a deprivation history, and social deficits persist despite good care.
- Distinguish from intellectual developmental disorder, depressive disorders of early childhood, and PTSD following identified abuse.
- Cognitive and language delay, growth failure, and stereotypic movements are common comorbidities in institutionally reared children.
- The two attachment disorders describe opposite behavior patterns and are not diagnosed together, though both can follow the same deprivation.
- Base rates are very low in community samples but rise substantially among maltreated children in foster care and institutional settings.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication treats reactive attachment disorder itself, and pharmacotherapy is limited to clearly established comorbid conditions.
- Treat co-occurring ADHD, depression, or PTSD with standard evidence-based agents once the caregiving environment has been stabilized.
- Avoid antipsychotics prescribed for behavioral control; they carry metabolic risk without addressing the underlying attachment deficit.
- Reassess medication need after placement stabilizes, since many symptoms remit once consistent and responsive caregiving is established.
- Monitor growth, sleep, and nutrition closely, because deprivation-related failure to thrive can confound apparent psychotropic effects.

PSYCHOTHERAPY

- The first intervention is securing an emotionally available attachment figure; nothing else works while the caregiving situation remains disrupted.
- **Attachment and Biobehavioral Catch-up** delivers 10 home-based sessions coaching foster parents in nurturance and following the child's lead.
- **Child-Parent Psychotherapy** treats the caregiver-child dyad over roughly a year and has randomized support in maltreated preschoolers.
- **Parent-Child Interaction Therapy** and video-feedback interventions build caregiver sensitivity while reducing disruptive child behavior.
- Holding therapy, rebirthing, and other coercive attachment therapies are contraindicated, lack evidence, and have caused child deaths.

ADJUNCT & SUPPORTIVE

- AACAP guidance places caregiver-focused intervention first and warns explicitly against coercive or restraint-based attachment treatments.
- Coordinate with child welfare to minimize placement moves, since each disruption resets the attachment the child is beginning to build.
- Assess with the **Disturbances of Attachment Interview** and structured caregiver-child observation rather than symptom checklists alone.
- Arrange early intervention for language, motor, and cognitive delay, which co-occur in most previously institutionalized young children.
- Support foster and adoptive parents directly with respite, training, and their own mental health care to reduce placement breakdown.

CLINICAL PEARLS

- RAD is a caregiving-environment diagnosis; treat the caregiver, not the child alone.
- Autism persists in good care; RAD symptoms remit once attachment forms.
- Holding and rebirthing therapies are dangerous and have killed children.

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NOTE

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